Anthem Lumenos

Your Benefits

City of Brazil
Lumenos Health Reimbursement Accounts Option 6
Summary of Benefits, Effective 08/01/2008

Covered Benefits	Network	Non-Network
Employer Health Account Contribution Single: $208.33 Family: $416.67		
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage. Network and Non-Network deductibles are combined.	Single: $1,500 Family: $3,000	Single: $1,500 Family: $3,000
Employee Bridge Amount **	Single: $1291.67 Family: $2,583.33	Single: $1,291.67 Family: $2,583.33
Out-of-Pocket Limit	Single: $1,500 Family: $3,000	Single: $3,000 Family: $6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) · Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%/0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams, Routine Mammograms, Diabetic Education, and Certain Medical Nutritional Therapy (Network only). · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility	 No Cost Share No Cost Share	 30% 30%
Emergency and Urgent Care **· Emergency Room Services @Hospital (facility/other covered services)** *(copayment waived if admitted)* **· Urgent Care Center Services**	0% 0%	0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	0%	30%

Covered Benefits	Network	Non-Network
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment and Orthotics (Network/Non-network combined) $4,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) · Prosthetic Devices $4,000 benefit maximum · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	0% 0% 0%	30% 0% 0%
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits	 0%/0% 0%	 30% 30%
Behavioral Health Services: **Mental Health and Substance Abuse (1)** · Inpatient Facility Services · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility	 0% 0%/0% 0%	 30% 30% 30%
Human Organ and Tissue Transplants · Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs: **· Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip **· Anthem Rx Direct Mail Service:** (90-day Supply) Includes diabetic test strip **Medicare RX - Wrap**	 0% 0%	 30%(2) Not Covered
Lifetime Maximum (Combined Network and Non-Network) (3)	$5 million	$5 million

Notes:

· *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
· *Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance including prescription drugs.*
· *Network and Non-network deductibles are combined. Network and Non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.*
· *Dependent age: to the end of the calendar year in which the child attains age 24.*
· *0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment. No cost share means no deductible or coinsurance up to the maximum allowable amount.*
· *PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.*
· *SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.*
· *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
· *Benefit period = calendar year*

(**) Bridge is not an insurance term and does not appear in the Certificate. HRA funds can be used for covered services under the benefit plan. Bridge amounts may be reduced if Incentives are earned and by Contribution Rollover amounts in subsequent years. Employer must fund in order to be considered a Health Reimbursement Account. Employer must continue to fund for the entire year at the HRA level indicated.
(1)We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to

Schedule of Benefits for limitations.
(2)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
(3)Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.

Precertification:
· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:
We will not provide benefits for services, supplies, or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical), which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.